CADH

Connecticut Association of Directors of Health, Inc.

241 Main Street
2nd Floor
Hartford, CT 06106
Ph: 860-727-9874
Fx: 860-493-0596
www: cadh.org

Testimony Regarding Senate Bill 1340
Public Health Committee
March 5, 2007

Senator Handley, Representative Sayers, and Members of the Public Health Committee. I am Dr. Patricia Checko, Director of Health for the Bristol-Burlington Health District and a member of the Connecticut Association of Directors of Health. I speak to you on behalf of all local health departments in the state regarding the issue of lead poisoning in children.

The overall reduction in childhood lead levels over the last three decades has been one of the great public health success stories in our country. In Connecticut, local health departments have been instrumental in helping reduce the deleterious effects of childhood poisoning. Since the late 1990's when legislative regulations were put in place – local health has had the sole authority for enforcing them. This has been done with NO funding.

There are still too many lower-income children living in older housing who are being hurt by elevated blood levels and we all care about changing that. Your local health departments are major partners in the secondary prevention interventions to prevent further lead exposure and decrease the blood levels of children with elevated lead blood levels. Currently, laboratories are required to report all Blood Lead Levels (BLL) $\geq$ 10µg/dL to the state and local health departments. Physicians are required to report children with levels $\geq$20 µg/dL. And local health departments are required to respond.

I would like to tell you what happens at your local health department when a report of an elevated blood lead level (BLL) of $\geq$ 20 µg/dL is received.

- The public health nurse initiates contact the parent to discuss the case and set an appointment for a home visit.
- The nurse and sanitarian (certified in lead inspections) visit the home. The nurse speaks with the parent, completing an extensive epidemiologic questionnaire to identify behaviors and lead exposures and provides education about diet and nutrition, housekeeping and methods to reduce exposure. The sanitarian conducts a tedious and thorough inspection of the dwelling. The sanitarian uses a special machine to measure any lead that may be in exposed surfaces and window sills and jams. This inspection may take an entire day.
- The sanitarian also collects samples of dust, soil and water, as required by DPH regulations.

- Once environmental test results are available, if abatement or remediation is necessary, the Director of Health serves the property owner(s) with a written order requiring them to conduct the necessary abatements, once a written plan is submitted and approved by the local health department. This order is appealable, and more likely than not, the landlord will appeal, requiring a hearing before the state DPH hearing officer.
- When abatement is completed, the LHD must reexamine and retest the dwelling for residual lead before approval of the process and closure of the environmental part of the case.
- If necessary, the family may need to be relocated on a temporary basis while work is being completed, and in some cases permanent lead safe housing must be sought.
- The public health nurse continues to coordinate with the physician and the family until the child's BLL returns to15 µg/dL or less, when the case can be closed.
- All this is being done while our sanitarians and public health nurses are working on a myriad of other mandated activities and the LHD is required to submit numerous reports to DPH and attempt to meet statutory timelines that are difficult to achieve. It can take months and even years to get the landlord to comply with our orders.

The proposed legislation mirrors the recommendations of CDC and the Advisory Committee on Childhood Lead Poisoning Prevention published in March 2002. This guidance recommends that the same follow up I described above for children with BLLs of ≥20 µg/dL be undertaken for all children with levels of 15 to 19. I have attached a table from that guidance that describes what should be done at various blood levels.

While we support more aggressive actions at lower levels I need to share the effect in workload that this will entail. I am using data from CY2004, the last year for which the DPH has information available.

Table 1. Children 1 to 2 Years of Age with Confirmed Blood Lead Levels ≥10 µg/dL in CY 2004

Location	10-14 µg/dL	15-19 µg/dL	≥20 µg/dL
Connecticut	504	177	178
New Haven	86	34	38
Naugatuck Valley	16	4	22

Statewide there would be a doubling of cases requiring case management, epidemiologic and environment investigation and remediation or abatement. We already have an overburdened and underfunded local public health system. While we support the intent of this bill and work hard everyday to protect children from the deleterious effects of blood lead poisoning, local health departments WILL NOT be able to meet the additional mandates of this bill. This work takes trained public health professionals.

There are also a number of new requirements in the bill that are unclear or different from the Department's current regulations that need to be clarified and further fleshed out, such as the issue of "remediation" and enforcement of exterior lead paint removal regulations.

Public health is about Prevention, Promotion and Protection. Eliminating childhood lead poisoning is important and we are committed to it as are the sponsors of this bill. While we support the intent of this bill, we cannot meet its mandates without additional funding. Our CADH representatives, particularly our Lead Committee members would be happy to sit down with the authors of the bill to discuss potential problems and solutions for implementation as well as the resources to reduce and someday eliminate childhood lead poisoning in Connecticut.

Thank you.

Table 3.1. Summary of Recommendations for Children with Confirmed (Venous) Elevated Blood Lead Levels

Blood Lead Level (µg/dL)				
10-14	15-19	20-44	45-69	≥70
• Lead education – Dietary – Environmental • Follow-up blood lead monitoring	• Lead education – Dietary – Environmental • Follow-up blood lead monitoring • Proceed according to actions for 20-44 µg/dL if: – A follow-up BLL is in this range at least 3 months after initial venous test **or** – BLLs increase	• Lead education – Dietary – Environmental • Follow-up blood lead monitoring • Complete history and physical exam • Lab work: – Hemoglobin or hematocrit – Iron status • Environmental investigation • Lead hazard reduction • Neurodevelop-mental monitoring • Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated	• Lead education – Dietary – Environmental • Follow-up blood lead monitoring • Complete history and physical exam • Complete neurological exam • Lab work: Hemoglobin or hematocrit – Iron status – FEP or ZPP • Environmental investigation • Lead hazard reduction • Neurodevelop-mental monitoring • Abdominal X-ray with bowel decontamination if indicated • Chelation therapy	• Hospitalize and commence chelation therapy • Proceed according to actions for 45-69 µg/dL

The following actions are NOT recommended at any blood lead level:

- Searching for gingival lead lines
- Testing of neurophysiologic function
- Evaluation of renal function (except during chelation with EDTA)
- Testing of hair, teeth, or fingernails for lead
- Radiographic imaging of long bones
- X-ray fluorescence of long bones